Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

972

JAMES WEISS MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Respondent Name
HOUSTON ISD

Carrier's Austin Representative Box
Box Number 21

MFDR Tracking Number
M4-11-2197-01

MFDR Date Received
MARCH 3, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has failed to properly reimburse this injured workers claim for diagnostic testing even after the claim was sent back to the carrier as a request for reconsideration."

Amount in Dispute: $340.94

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed $1,512.84 and the Carrier paid $1,171.90 in accordance with the Medical Fee Guidelines. The provider is using Trailblazer to calculate the reimbursement amounts and the Division has stated in the Medical Fee Guidelines training seminars that using Trailblazer arrives at approximate amounts, rather than exact amounts if the CMS website is used. The Carrier's position is that it paid in accordance with Medical Fee Guidelines and no further reimbursement is due."

Response Submitted By: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2010	CPT Code 99203	$0.44	$0.00
	CPT Code 95861 (X1)	$0.54	$0.00
	CPT Code 95900(X4)	$328.44	$0.00
	CPT Code 95904 (X4)	$0.84	-$0.03
	CPT Code 95903 (X4)	$1.17	$0.03
	CPT Code 95934 (X2)	$0.45	$0.00
	HCPCS Code A4566	$9.06	$0.00

TOTAL		$340.94	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-Payment is included in the allowance for another service/procedure.
   - W1-Workers compensation state fee schedule adjustment.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time..

Issues

1. Is the requestor entitled to additional reimbursement for CPT codes 99203, 95861, 95903, 95904 and 95934?
2. Is the allowance for CPT code 95900 included in the allowance of CPT code 95903?
3. Is the requestor entitled to reimbursement for HCPCS code A4566?

Findings

1. The respondent states in the position summary that "it paid in accordance with Medical Fee Guidelines and no further reimbursement is due."

   The issue in dispute is whether the requestor is due additional reimbursement for the disputed services.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

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   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.8729

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77027, which is located in Houston, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Houston, Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality Houston	Maximum Allowable	Carrier Paid	Due
99203	(54.32/36.8729) x $101.77 for 1 Unit	$149.92	$149.93	$0.00
95861	(54.32/36.8729) x $123.95 for 1 Unit	$182.59	$182.59	$0.00
95903	(54.32/36.8729) x $65.02 for 4 Units	$383.14	$383.11	$0.03
95904	(54.32/36.8729) x $48.91 for 4 Units	$288.21	$288.24	-$0.03
95934	54.32/36.8729) x $51.62 for 2 Units	$152.09	$152.09	$0.00

1. According to the submitted explanation of benefits the respondent's denied reimbursement for CPT code 95900 based upon reason code "97."

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per The National Correct Coding Initiative Policy Manual "The NCCI edit with column one CPT code 95903 (Motor nerve conduction studies with F-wave study, each nerve) and column two CPT code 95900 (Motor nerve conduction studies without F-wave study, each nerve) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 95900 of this NCCI edit is appropriate only if the two procedures are performed on different nerves or at separate patient encounters." The requestor did not append modifier 59 to indicate that CPT code 95900 was a separate procedure; therefore, reimbursement is not recommended.

2. 28 Texas Administrative Code §134.203(d) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
   (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

   According to the DMEPOS fee schedule, HCPCS code A4556 has a total allowable of $12.74 for Texas. Per 28 Texas Administrative Code §134.203(d), the MAR is $15.92. The respondent paid $15.94. As a result, reimbursement of $0.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due for the specified services. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/10/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.